2020 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.

Benefit Description

Vision Services (Testing, Treatment, and Supplies)
Eye examinations or visits related to a specific medical condition.

You Pay
Preferred: $10 copayment (no deductible) per visit up to a combined total of 10 visits per calendar year (benefits combined with visits in Section 5(a) page 39)

Preferred provider, visits after the 10th visit: 30% of the Plan allowance

Non-preferred (Participating/Non-participating): You pay all charges

Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 131 for more information about “agents.”)

Benefit Description
Diagnostic testing and treatment, such as:

- Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21
- Lab, X-ray, and other diagnostic tests performed or ordered by your provider.
- Refraction, only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described below.

Note: See Section 5(b), *Surgical Procedures*, for coverage for surgical treatment of amblyopia and strabismus.

You Pay
Preferred: 30% of the Plan allowance

Non-preferred (Participating/Non-participating): You pay all charges

---

Benefit Description

Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed:

- To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery;
- If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition;
- For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21

You Pay
Preferred: 30% of the Plan allowance

Non-preferred (Participating/Non-participating): You pay all charges

---

Benefit Description

Not covered:

- *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described above*
- *Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.*
- *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom*
- *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above*
- *LASIK, INTACS, radial keratotomy, and other refractive surgical services*
- *Refractions, including those performed during an eye examination related to a specific medical condition, except as described above*

You Pay
All charges

vision
testing
treatment
supplies
examinations
diagnostic
treatement
nonsurgical
amblyopia
crossed
strabismus
lazy
eyes
laboratory
lab
x-ray
refraction
eyeglasses
lenses
contact
impairment
intraocular
polarization
multifocal
UV
IOLs
crystalens
restor
rezoom
lasic
intacs
keratotomy
refractive
radial